Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2220	A. BUILDING: _____ B. WING _____	09/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HACIENDAS AT GRACE VILLAGE, LLC - UNIT D	2802 CORTE DIOS LAS CRUCES, NM 88011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited during a Full-Onsite survey completed on 09/30/22 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living for Adults.	A 000		
A 017	7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with	A 017	The facility will continue to ensure that the direct care staff will receive all the required orientation and annual training. The facility will put more focus on the documentation of current in-service training, document individual participation in the training more closely, and track attendance. Random audits will be conducted, a new tracking log will be created (a spreadsheet with all new hires date and checklist of completion). The administrator or designee with monitor. Facility started audit on Oct 10, 2022. An audit will be conducted quarterly.	

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Admr

(X6) DATE 11/3/22

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A 017	Continued From page 1 medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.17 A B C (1 - 12) Based on record review and interview, the facility failed to ensure that the (DCS) Direct Care Staff training files included complete documentation of the DCS receiving and completing 16 hours supervised training prior to providing unsupervised resident care and of completing the required 12 hours of orientation training, with proof of competency. This deficient practice could likely result in the 12 (R #s 1-12) residents listed on the resident census, provided by the Administrator on 09/29/22, to be at risk of harm if they are receiving care and services by DCS who have not received the required trainings. The findings are: A. Record review of DCS #1s employee file (hire date 07/28/22), revealed no documentation of the following training requirements with proof of competency: 1. Sixteen (16) hours of supervised training prior to providing unsupervised care for residents. 2. Completion of an acceptable Medication Assistance training course.	A 017		

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A 017	Continued From page 2 3. Twelve (12) hours of training at orientation, with proof of competency. B. Record review of DCS #2s employee file (hire date 01/06/22), revealed no documentation of the following training requirements with proof of competency: 1. Sixteen (16) hours of supervised training prior to providing unsupervised care for residents. 2. Completion of an acceptable medication assistance training course. 3. Twelve (12) hours of training at orientation with proof of competency. C. On 09/27/22 at 09:27 am, during an interview with the Administrator, she confirmed that DCS #s 1 and 2 staff files did not contain documentation of the DCS completing required training that included: 1. Sixteen (16) hours of supervised training prior to providing unsupervised care for residents. 2. An acceptable medication assistance training course. 3. Twelve (12) hours of training at Orientation with proof of competency.	A 017		
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be	A 025	The facility will ensure that admission evaluations are completed prior to 15 calendar days of admission. A checklist will also be kept for tracking the 15-calendar day admission completed, along with a 6-month audit or when there are significant changes with a resident or move to a different buildings. Campus Nurse or designee with monitor.	

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A 025	Continued From page 3 reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse,	A 025	Campus Nurse will continue to audit and update all current resident evaluations and ISPs by 12-20-2022.	

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A 025	Continued From page 4 registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.25 A B Based on record review and interview the facility failed to ensure for 3 (R #s 1-3) of 3 (R #s 1-3) residents whose evaluations were reviewed for compliance that: 1. They were completed within 15 calendar days of admission. 2. They were reviewed and if needed updated at a minimum of every 6 months or when there were significant changes in health status. 3. When residents were moved from one building to another facility building that functions independently with separate State of New Mexico License numbers, that a new evaluation was completed. A. Record review of R #1's (Admission Date: [redacted]16), initial evaluation completed on [redacted]6, revealed it was not completed within 15-days prior to admission and there was no documentation of any evaluations being completed at a minimum of every 6 months. B. Record review of R #2's resident file (Original admission on unknown date in 2020 and again on [redacted]22) revealed:	A 025		

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A 025	Continued From page 5 1. An Evaluation dated 06/20/20, admission dated not documented. 2. No documentation of an Evaluation being completed when the resident was admitted a second time on [redacted]22. 3. No documentation of an Evaluation being completed when the resident was admitted to Hospice [redacted]22. 4. No documentation of Evaluations being completed at a minimum of every 6 months. C. Record review of R #3's resident file (Original admission on unknown date in 2016 and again on [redacted]21) revealed: 1. An Evaluation dated [redacted]6, admission date not documented. 2. No documentation of an Evaluation being completed when the resident was admitted a second time on [redacted]21. 3. No documentation of Evaluations being completed at a minimum of every 6 months. D. On 09/28/22 at 3:37 pm, during an interview with the Administrator, she confirmed that the resident evaluations for R #s 1-3 had not been completed prior to admission and/or updated: 1. At a minimum of every 6 months. 2. When there were changes in condition. 3. When residents were moved from one of the other (3) three facility to another facility with at different license number, even though they all had the same owner.	A 025		
A 065	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one	A 065	The facility confirms compliance with the fire drill regulation as mandated by the NMHD conduct fire drills on a monthly basis. The facility promptly began Oct 3, 2022.	

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A 065	Continued From page 6 documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show: (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.65 A B (3-5) Based on record review and interview, the facility failed to ensure that fire drills conducted monthly included the following information documented: 1. The number of residents participating in the fire drill was documented. 2. Problems experienced during the fire drill were documented. This deficient practice could likely result in the 12 (R #s 1-12) residents identified on the census, provided the Administrator on 09/28/22, to be at risk of harm, injury, or death if a fire were to occur and the Direct Care Staff (DCS) do not know how to safely evacuate the residents from the building. The findings are:	A 065	Staff will participate in actual fire drill and staff training will be provided. Documentation will also be kept for any resident needing additional assistants if needed during a fire drill. And if any other concern (problems) occurs it will also be documented and used for training. On-going proper fire drill regulation to be followed monthly. The Administrator or designee with monitor	

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A 065	Continued From page 7 A. Record review of the facility's fire drill records for the months of July, 2022 and August, 2022 revealed: 1. No documentation of residents participating in the fire drills. 2. No documentation of an problems experienced during the fire drill. B. On 09/28/22 at 5:18 pm, during an interview with the Administrator, she confirmed that the Building D fire drill records reviewed for the months of July, 2022 and August, 2022 did not include documentation of: 1. The number of residents participating because the facility does not include residents in the fire drills. 2. Problems that may have occurred during the fire drills.	A 065		
A 066	7 NMAC 8.2.66 Staff and Resident Fire and Safety Training STAFF AND RESIDENT FIRE AND SAFETY TRAINING: A. All staff of the facility shall know the location and the proper use of fire extinguishers and the other procedures to be followed in case of fire or other emergencies. The facility should request the local fire prevention authority to give periodic instructions in the use of fire prevention and techniques of evacuation. B. Facility staff shall be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, blocked exits or exit-ways and any other condition which could cause burns, falls, or other personal injury to the residents or staff. C. Each new resident admitted to the facility shall	A 066	The facility will confirm compliance with the fire drill regulation as mandated by the NMHD to comply with performing fire drills on monthly basis, and cover one per month to assure all shifts are covered every quarter. Upon hiring and annually staff will participate in actual education and fire drill training per NMHD 8.2.66.A.S. Staff will participate in actual fire drill and staff training will be provided. Documentation will also be kept for any resident needing additional assistants if needed during a fire drill. And if any other concern (problems) occurs it will also be documented and used for training, including fire extinguishers, fire	

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A 066	Continued From page 8 be given an orientation tour of the facility to include the location of the exits, fire extinguishers and telephones and shall be instructed in the actions to be taken in case of fire or other emergencies. D. Fire drill procedures. The facility must conduct at least one (1) fire drill each month. (1) Fire drills shall be held at different times of the day, evening and night. (2) The fire alarm system or detector system in the facility shall be used in the fire drills. During the night, the fire drill alarm may be silenced. (3) During the fire drills, emphasis shall be placed upon orderly evacuation under proper discipline rather than upon speed. (4) A record of the conducted fire drills shall be maintained on file in the facility. The record shall show the date and time of the drill, the number of personnel participating in the drill, any problem(s) noted during the drill and the evacuation time in total minutes. (5) The local fire department may be requested to supervise and participate in the fire drills. [7.8.2.66 NMAC - Rp, 7.8.2.63 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.66 A B C D (3-4) Based on record request, record review, and interview the facility failed to ensure that the: 1. Direct Care Staff (DCS) were trained on the procedures to detect and eliminate potential safety hazards, properly use fire extinguishers, evacuation techniques and the other procedures in case of fire or other emergencies. 2. Residents were informed of the location of the	A 066	exit, and any other matters that occur. On-going proper fire drill regulation to be followed monthly. The facility promptly completed a fire inspection on October 6, 2022. The Administrator or designee with monitor	

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A 066	Continued From page 9 facility fire exits, fire extinguishers, and instructed in the actions to take in case of a fire or other emergency. 3. Monthly fire drills were conducted in the facility that place emphasis on orderly evacuation of the facility. These deficient practices could likely result in all 12 (R #s 1-12) residents listed on the census, provided by the Administrator on 09/28/22, to be at risk of harm, injury, or death if a fire or other emergency that required evacuation were to occur, if the: 1. DCS do not know the procedures to follow in order to eliminate safety hazards, how to use a fire extinguishers, or how to orderly evacuate residents from the facility. 2. Residents have not received evacuation training, and do not know how to safely evacuate the facility. 3. DCS are not aware of resident issues that occur during the evacuation or the time it takes for the staff to safely evacuate the residents from the facility. The findings are: A. Record request for DCS #s 1-3 training records, revealed no documentation that the DCS completed Fire Safety training that included: 1. The procedures to detect and eliminate potential safety hazards. 2. Proper use a fire extinguishers. 3. Evacuation techniques. B. Record review of R #s 1-3 resident records, revealed no documentation that the resident/families fire safety orientation that included: 1. The location and use of fire extinguishers,	A 066		

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A 066	Continued From page 10 2. Location of fire exits, 3. Instruction on the actions to take in case of a fire or other emergency. C. Record review of the facility Monthly Inspections report dated 08/22/22, revealed that the facility: 1. Conducted and documented a Monthly fire drill on 08/25/22. at 3:20 pm. 2. The 08/25/22 Fire Drill notes for Building D revealed that the facility did not: a. Place emphasis on orderly evacuation (of residents) from the facility. b. Have residents participate in the evacuation of the facility during fire drills. D. On 09/28/22 5:18 pm, during an interview with the Administrator, she confirmed that there was no documentation available for review for the following: 1. Fire Safety training records for DCS #s 1-3 including: a. Completing fire drill training. b. Completing training that included the procedures to detect and eliminate potential safety hazards, c. Being trained on the proper use fire extinguishers. d. Being trained on evacuation techniques. 2. Documentation of R #s 1-3, receiving orientation training that included: a. How to evacuate to the nearest emergency exit. b. The location and use of fire extinguishers. c. The location of telephones that can be used in an emergency. d. Being instructed in the actions to be taken in case of fire or other emergencies. e. Evacuation time in minutes for residents evacuating to the emergency exits during fire	A 066		

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A 066	Continued From page 11 drills. E. On 09/28/22 at 5:18 pm, during an interview with the Administrator, she confirmed that the facility did not: 1. Include residents in the monthly Fire Drills. 2. Document any problems related to residents evacuating the facility. 3. Document the total time in minutes for residents to evacuate the facility because residents are not participating in the fire drills.	A 066		